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BEFORE THE DEPARTMENT OF MANAGED HEALTH CARE

OF THE STATE OF CALIFORNIA

IN THE MATTER OF THE ACCUSATION AGAINST:	Enforcement Matter No. 04-215
AETNA Health of California, Inc.	OAH No.
	ACCUSATION
Respondent.	Health & Safety Code § 1374.30(m) And (d)(1, (2), & (3).

I.

INTRODUCTION

This case is brought pursuant to the provisions of the Knox-Keene Health Care Service Plan Act of 1975 (the "Act," Health and Safety Code, section 1340 *et. seq.*) based on the failure of AETNA Health of California, Inc., ("Respondent" or "Plan"), to include the Independent Medical Review (IMR) application and return envelope along with its denial, modification, or delay of health care services to an enrollee. Respondent's conduct in failing to provide the IMR application and return envelope was in violation of Health and Safety Code section 1374.30, subdivision (m). This violation constitutes cause for discipline by the Director of the Department of Managed Health Care ("Director" or "the Department") pursuant to Health and Safety Code section 1386, subdivisions (a) and (b)(6).

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II.

PARTIES

1. Amy L. Dobberteen ("Complainant") is the Assistant Deputy Director of the California Department of Managed Health Care, Office of Enforcement. Complainant brings this accusation solely in her official capacity as Assistant Deputy Director of the Office of Enforcement for the Department of Managed Health Care.

2. At all times pertinent to the allegations herein, Respondent has been a full-service health care service plan as defined by Health and Safety Code section 1345, subdivision (f), and is subject to the regulatory provisions of the Act. Respondent is the holder of a health care service plan license number 933-0176, issued on August 6, 1981, by the Commissioner of the Department of Corporations, predecessor to the Director of the California Department of Managed Health Care. Respondent's principal corporate office is located at 2409 Camino Ramon, San Ramon, California 94583.

III.

JURISDICTION

3. This Accusation is brought before the Director of the Department of Managed Health Care under the authority of the following sections of the Health and Safety Code.

4. Health and Safety Code section 1340 *et seq.* of the Act was enacted in 1975 to provide state regulation of health care service plans. The Act was amended in 1999 to create the Department of Managed Health Care within the California Business, Transportation, and Housing Agency.[1] The Department has charge of the execution of the laws of the state relating to health care service plans. The statutory mission of the Department, as set forth in Health and Safety Code section 1341, subdivision (a), is to ensure that health care service plans provide enrollees with access to quality health care services and to protect and promote the interests of enrollees.

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[1] Effective July 1, 2000, the Department of Managed Health Care succeeded to all duties, powers, responsibilities, and jurisdiction of the Department of Corporations as they related to Corporations' Health Plan Program, health care service plans and the health care service plan business. (Health and Saf. Code, §1341.9)

5. The Director is vested with the responsibility for the administration and enforcement of the provisions of the Act and the rules and regulations thereunder pursuant to Health and Safety Code section 1341.

6. Section 1374.30, subdivision (m), of the Health and Safety Code delineates the parameters of the responsibility that the Respondent has in notifying an enrollee of the IMR process when it rules on an enrollee grievance:

> (m) As part of its notification to the enrollee regarding a disposition of the enrollee's grievance that denies, modifies, or delays health care services, the plan shall provide the enrollee with a one-page application form approved by the department, and an addressed envelope, which the enrollee may return to initiate an independent medical review. The plan shall include on the form any information required by the department to facilitate the completion of the independent medical review, such as the enrollee's diagnosis or condition, the nature of the disputed health care service sought by the enrollee, a means to identify the enrollee's case, and any other material information. The form shall also include the following:
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> (1) Notice that a decision not to participate in the independent medical review process may cause the enrollee to forfeit any statutory right to pursue legal action against the plan regarding the disputed health care service.
>
> (2) A statement indicating the enrollee's consent to obtain any necessary medical records from the plan, any of its contracting providers, and any out-of-plan provider the enrollee may have consulted on the matter, to be signed by the enrollee.
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> (3) Notice of the enrollee's right to provide information or documentation, either directly or through the enrollee's provider, regarding any of the following:
> (A) A provider recommendation indicating that the disputed health care service is medically necessary for the enrollee's medical condition.
> (B) Medical information or justification that a disputed health care service, on an urgent care or emergency basis, was medically necessary for the enrollee's medical condition.
> (C) Reasonable information supporting the enrollee's position that the disputed health care service is or was medically necessary for the enrollee's medical condition, including all information provided to the enrollee by the plan or any of its contracting providers, still in the possession of the enrollee, concerning a plan or provider decision regarding disputed health care services, and a copy of any materials the enrollee submitted to the plan, still in the possession of the enrollee, in support of the grievance, as well as any additional material that the enrollee believes is relevant.

7. Health and Safety Code section 1374.30, subdivision (d), makes clear the Department, not the health care service plan, makes the final decision whether the denial, modification, or delay of health care services is based on a consideration of medical necessity or a coverage decision:

> (d)(1) All enrollee grievances involving a disputed health care service are eligible for review under the Independent Medical Review System if the requirements of this article are met. If the department finds that an enrollee grievance involving a disputed health care service does not meet the requirements of this article for review under the Independent Medical Review System, the enrollee request for review shall be treated as a request for the department to review the grievance pursuant to subdivision (b) of Section 1368. All other enrollee grievances, including grievances involving coverage decisions, remain eligible for review by the department pursuant to subdivision (b) of Section 1368.
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> (2) In any case in which an enrollee or provider asserts that a decision to deny, modify, or delay health care services was based, in whole or in part, on consideration of medical necessity, the department shall have the final authority to determine whether the grievance is more properly resolved pursuant to an independent medical review as provided under this article or pursuant to subdivision (b) of Section 1368.
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> (3) The department shall be the final arbiter when there is a question as to whether an enrollee grievance is a disputed health care service or a coverage decision. The department shall establish a process to complete an initial screening of an enrollee grievance. If there appears to be any medical necessity issue, the grievance shall be resolved pursuant to an independent medical review as provided under this article or pursuant to subdivision (b) of Section 1368.

8. Section 1386, subdivision (a), of the Health and Safety Code authorizes the Director of the Department to take disciplinary action against a health care service plan, including, but not limited to, the assessment of administrative penalties against the plan, if the Director determines, after appropriate notice and opportunity to be heard, that the plan has committed any of the acts or omissions which constitute grounds for disciplinary action pursuant to the provisions of the Act.

9. Section 1386, subdivision (b)(6), of the Health and Safety Code sets forth as an act or omission which constitutes ground for disciplinary action by the Director that the

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plan violated or attempted to violate, or conspired to violate, directly or indirectly, or assisted in or abetted a violation or conspiracy to violate any provision of this chapter or any rule or regulation adopted by the Director pursuant to this chapter.

10. As described in detail below, the Respondent is subject to disciplinary action under Health and Safety Code section 1386 and the assessment of an administrative penalty for a violation of Health and Safety Code section 1374.30, subdivision (m).

IV.

FACTUAL ALLEGATIONS

11. On November 10, 2003, Human Affairs International of California ("HAI"), on behalf of Respondent AETNA Health of California, denied the enrollee's request for continuation of the enrollee's outpatient behavioral health treatment stating the enrollee's request was "outside of the 90 day transition period."

12. On November 21, 2003, the enrollee appealed the denial to Respondent.

13. On November 24, 2003, the Respondent denied the enrollee's appeal stating "the request for transition of care benefits for outpatient behavioral health treatment with Helen Siepser, M.D., was received beyond the 90 day enrollment period."

14. The Respondent did not include a one-page IMR application form and return envelope with the Respondent's November 24, 2003, appeal denial letter.

V.

FIRST CAUSE FOR DISCIPLINE

FAILURE TO INCLUDE IMR FORM AND RETURN ENVELOPE

15. Complainant incorporates by reference paragraphs 1 through 15, as stated above, as though fully stated herein.

16. The Respondent is subject to assessment of an administrative penalty for violating Health and Safety Code section 1374.30, subdivision (m), for failing to include an IMR application form and a return envelope with Respondent's denial of the enrollee's request for health care services.

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VI.

DISCIPLINARY CONSIDERATIONS

17. The Director of the Department has the discretion, pursuant to the provisions of Health and Safety Code section 1386, subdivision (a), to suspend or revoke the license of a health care service plan for violations of the Act, as well as to assess administrative penalties for violations of the Act.

18. Complainant has considered the following factors in seeking an assessment of an administrative penalty of $2,500.00 against the Respondent in this action:

(a) The Plan has not demonstrated any type of corrective action to ensure the violation will not recur.

(b) This particular violation is not an isolated incident.

(c) The assessed penalty of $2,500.00 is necessary to deter future violations of Health and Safety Code section 1374.30, subdivision (m).

VII.

PRAYER

WHEREFORE, Complainant prays that a decision be rendered by the Director of the Department of Managed Health Care assessing an administrative penalty against the Respondent, AETNA Health of California, Inc., in the amount of $2,500.00 for a violation of the Knox-Keene Act committed as alleged in this accusation.

WHEREFORE, Complainant also prays for such other and further relief, as the Director deems proper.

Dated: February 24, 2005

AMY L. DOBBERTEEN
Assistant Deputy Director
Department of Managed Health Care

By: _____
BRENDA A. RAY
Senior Counsel
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